

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:	MFDR Tracking #:	M4-03-7923-01
RIO VISTA REHABILITATION HOSPITAL		
PO BOX 809053		
DALLAS TX 75380-9053		
Respondent Name and Box #:		
Insurance Co. of the State of Pennsylvania		
Box #: 19		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary "This facility accepts 75% of the total charges as fair and reasonable"

Principle Documentation:

1. DWC 60 package
2. Hospital Bill
3. Total Amount Sought \$327.53

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Carrier has received additional documentation from the provider, but this additional documentation does not appear to be regarding the DOS in dispute of 6/25/2002."... "It is the Carrier's position that the provider has not properly billed the services in accordance with the TWCC MFG, nor has it appropriately documented the services billed. The provider has not established entitlement to reimbursement based upon the MFG, nor based upon any reimbursement scheme currently utilized. The Provider's original TWCC-60 indicates that there is no CPT code (?) and that the facility accepts 75% of the total charges as fair and reasonable. The provider has submitted no documentation to support the claimant [sic] of fair and reasonable, nor has the provider even submitted documentation relevant to the services rendered on the DOS in dispute."... "This request for medical dispute resolution should be dismissed at this time as the provider has not submitted original or reconsideration EOBs to document that the Carrier has ever had the opportunity to review these charges, nor any documentation that supports Carrier's receipt of the relevant billing if no response was ever received from the carrier. Also, as previously noted, the most recently received medical records are not even relevant to the DOS in dispute of 6/25/2002."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
6/25/2002	No EOB submitted for review	"N/a"	\$327.53	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. No EOB for the disputed services was submitted for consideration in this dispute. Division rule at 28 TAC §133.307(e)(2)(B), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003, requires that each copy of the request shall include “A copy of each explanation of benefits (EOB)”... “relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB.” This request for medical fee dispute resolution was received on June 20, 2003. Review of the documentation submitted by the requestor finds that the requestor has not met the requirements of Division rule at 28 TAC §133.307(e)(2)(B).
2. Review of the *Table of Disputed Services* submitted by the requestor finds that the requestor has not listed the CPT codes for the services in dispute. Division rule at 28 TAC §133.307(e)(2)(C), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003, requires that each copy of the request shall include “a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission” [currently the Division]. The *Table of Disputed Services* submitted by the requestor lists the CPT code(s) for the services in dispute as “N/a”. Review of the Table finds that the requestor has not listed the disputed health care and charges in the form, format and manner prescribed by the Division sufficient to meet the requirements of Division rule at 28 TAC §133.307(e)(2)(C).
3. Review of the documentation submitted by the requestor finds that the requestor did not submit additional documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(A-C), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003. Review of the documentation finds the following: (a) The requestor did not provide a copy of the response to the request for reconsideration, or if the carrier failed to respond, convincing evidence for the carrier’s receipt of that request; (b) The requestor did not provide a copy of any medical records pertinent to the services in dispute; (c) The requestor did not submit a statement of the disputed issues including a description of the disputed services; and, (d) The requestor did not state its reasoning for why the disputed services should be paid; or how the Texas Labor Code and Division rules impact the disputed fee issues; or how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division notes that the requestor submitted as additional information, received by the Division on June 8, 2004, a hospital bill and medical records pertinent to services rendered to the same injured worker in August of 2002, however none of the additional documentation received was relevant to the disputed date of service 6/25/2002. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(A-C).
4. This dispute relates to outpatient physical therapy services performed in a hospital setting on June 25, 2002 with reimbursement subject to the provisions of Division Rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011”...
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement”... The request for medical fee dispute resolution was received by the Division on June 20, 2003. Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Reimbursement cannot be recommended.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the additional reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(e)(2)(B), §133.307(e)(2)(C), §133.307(g)(3)(A), §133.307(g)(3)(B), §133.307(g)(3)(C), and §133.307(g)(3)(D). Additionally, the Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, § 134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. Please include a copy of the Medical Fee Dispute Resolution Findings and Decision together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.